controversial. They were introduced under the previous chief medical officer, Kenneth Calman, to align the UK system of specialist training with the requirements of the European Union directive on medical training.[8] The recommendations included combining the registrar and senior registrar grades into a unified specialist registrar grade, and the curriculum and minimum training requirements for each specialty were defined. Formal educational agreements were designed to emphasise structured learning as well as apprenticeship. Successful completion of the training leads to admission to the specialist register.

Introduction of the new system, for which no additional resources were allocated, began in 1995 and was completed in 1997. There were concerns that the reduced training time, compounded by the reduction in working hours, would adversely affect the learning experience for specialist registrars. In addition, the reduction in the number of registrars together with their more formal training requirements would increase consultants' workload.[9]

In this issue of the *BMJ*, Paice et al from the North Thames deanery compare the results of two surveys on the impact of the Calman reforms, the first undertaken during the introduction period and the second two years later (p 832).[10] Over 3000 specialist registrars took part, giving participation rates of more than 70%. Trainees in all grades recorded greater satisfaction with their current posts. They did not believe that they were acquiring less experience or that job satisfaction had decreased. They also reported an improvement in consultant supervision. Though these results are gratifying—and surprising to some—the data also show that the educational aims of postgraduate training are far from being consistently fulfilled. In some specialties, for example, only a few trainees met their trainer to agree educational objectives; even fewer signed a learning agreement. The surveys sought opinions only from specialist registrars, not their trainers.

Nevertheless, this report from the largest postgraduate deanery, responsible for training 25% of UK specialist registrars, is helpful in providing information in an area beset with anecdote. The Calman reforms were initially introduced as a matter of public policy to make Britain's system of postgraduate education compatible with Europe's. Paice et al have sought to evaluate their educational impact. Such evaluations of policy decisions are to be welcomed whatever they reveal.

So what now? Can we relax in the knowledge that these changes will continue to bring benefits over the next few years?[11] Almost certainly not. This report shows that the improvements depended on increased consultant input. Evidence from other sources, including regional taskforces and GMC visits to medical schools,[12] indicates that the increasing clinical workload is making it hard to sustain improvements already achieved, far less maintain the momentum towards creating consistent, high quality postgraduate training. Moreover, the greatest improvements seem to have been made in the preregistration house officer and specialist registrar grades. What are we doing, for example, to help senior house officers meet their expectations of early professional training?[13] If we have learnt anything from the past decade of reform it is that the postgraduate training of doctors can't simply be fitted in round service: it takes planning and hard work.

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Healthy People 2010: objectives for the United States

Impressive, but unwieldy

In January the United States Department of Health and Human Services released *Healthy People 2010*, the nation's health goals for this decade.[1] The report contains 467 specific objectives grouped into 28 "focus areas" (see box). It is the third set of 10 year national goals put out by the department, following earlier versions for 1990 and 2000. Once again it prompts the questions raised by most target setting exercises—of manageability and accountability.[2]

The scope and depth of the report are impressive, reflecting four years' work and broad consultation with the public, health experts, and over 350 national organisations and 270 state agencies. It is grounded in scientific evidence and covers an array of health behaviours, environmental factors, and other important determinants of individual and community health. A toolkit has been developed to help build support for *Healthy People 2010* activities at the state and local levels,[3] and the public is being asked to join the campaign (www.health.gov/healthypeople/youcando/default.htm).

Healthy People 2010 has two overriding goals: to enhance life expectancy and the quality of life; and to eliminate health disparities between different segments of the population, including those relating to gender,

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***Healthy People 2010* focus areas**

- Access to quality health services
- Arthritis, osteoporosis, and chronic back conditions
- Cancer
- Chronic kidney disease
- Diabetes
- Disability and secondary conditions
- Educational and community based programmes
- Environmental health
- Family planning
- Food safety
- Health communication
- Heart disease and stroke
- HIV
- Immunisation and infectious diseases
- Injury and violence prevention
- Maternal, infant, and child health
- Medical product safety
- Mental health and mental disorders
- Nutrition and overweight
- Occupational safety and health
- Oral health
- Physical activity and fitness
- Public health infrastructure
- Respiratory diseases
- Sexually transmitted diseases
- Substance abuse
- Tobacco use
- Vision and hearing

race and ethnicity, education, income, disability, living in rural localities, and sexual orientation. The goal to eliminate health disparities moves beyond the *Healthy People 2000* goal of simply reducing them. The British government, in its strategy paper *Saving Lives: Our Healthier Nation*, has a goal to "reduce the health gap" but no specific target.[4 5] The World Health Organisation's European region, on the other hand, aims to reduce the health gap between socioeconomic groups within countries by at least a quarter in all member states by 2020.[6]

The *Healthy People 2010* goal to eliminate health disparities is laudable but has resulted in some unrealistic targets. For objectives that can be influenced in the short term by lifestyle choices, behaviours, and health services (using existing and known interventions), the target is set at "better than the best" currently achieved by any group, so that improvement occurs for all segments of society. For instance, the 2010 target for the prevalence of cigarette smoking among adults is 12% (from a 1997 baseline of 24%) because such a low rate already exists among college graduates and those aged over 64. Yet smoking prevalence is unlikely to fall by a percentage point a year from 1997 to 2010 given that it has not declined at all since 1990[7] and during the previous 25 years it decreased by only half a percentage point a year.[8] Mendez and Warner have shown that the target is virtually unattainable assuming plausible decreases in smoking initiation and increases in smoking cessation.[9]

A new and valuable feature is the designation of 10 "leading health indicators," which help to mitigate the unwieldy size and lack of focus in *Healthy People 2010*. The report envisions that all states and communities will be able to track progress through this small set of measures, which cover physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behaviour, mental health, injury and violence, environmental quality, immunisation, and access to health care.

When the draft *Healthy People 2010* report was out for public comment I pointed out several problems with the document,[10] many of which remain. Firstly, many objectives are targeted to state and local governments, healthcare providers and institutions, schools, employers, and others, but the responsibility of the federal government is poorly defined. Secondly, inconsistencies occur across focus areas, an unavoidable result of a process and document that have grown too large and complex. For example, one objective is to increase the number of positive messages about responsible sexual behaviour on television programming, but the equally important goal of eliminating positive images of tobacco and alcohol use on television was not included.

Thirdly, the enormous scope of *Healthy People 2010* threatens to divert too many resources from health improvement activities to tracking. Existing data for the objectives already come from 190 data sources, and additional data sources will be needed for 30% of the 467 objectives ("developmental" objectives). Better tracking is such a challenge that one objective is to increase the frequency of tracking all the other objectives and another to improve the timeliness of data release. Fourthly, most objectives are population based goals relating to the incidence or prevalence of diseases or health behaviours, the proportion of people in a particular group who receive care or counselling, and so on. Only about a quarter are targeted to specific institutions, professions, or jurisdictions. A higher proportion of objectives should be "actionable"—that is, they should designate specific bodies to be held accountable for achieving the objectives.[11]

Surgeon General David Satcher describes *Healthy People 2010* as "an encyclopedic compilation of health improvement opportunities for the next decade."[1] British health officials, on the other hand, rejected their previous government's "scattergun targets" and this time have set "tougher but attainable targets in priority areas … focused on the main killers: cancer, coronary heart disease and stroke, accidents, [and] mental illness."[4] The European region of the WHO has reduced the number of its objectives from 38 to 21, but even 21 is widely believed to be too many.[2] Which approach is more effective in achieving improvements in the public's health—developing a comprehensive set of health targets or a more focused one? Or does *Healthy People 2010* attain the benefits of each by designating leading indicators within its "encyclopaedic compilation"? A careful study of the different approaches used throughout the world would help us answer those questions.

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